RESERVE COMPONENT MEDICAL COVER SHEET
MILITARY MEDICAL SUPPORT OFFICE (24 Jul 2002)

1. Patient's LAST NAME, First Name MI.	2. Pay Grade	3. Social Security #	4. Date of Birth
_____ _____ ___	_____		

5. Branch of Service:

USAR* USNR* USMCR* USAFR* ARNG* ANG*

* For service members in an Inactive Duty status, appropriate eligibility documentation must be provided if treatment has been found to be a result of a service-connected injury.

6. Current Duty Station (work location)

_____ _____
Command UIC / OPFAC

_____
Street Address

_____ _____ _____
City State Zip Code

_____
Unit phone number (DSN or Commercial)

7. Patient's Home Address:

_____
Street Address

_____ _____ _____
City State Zip Code

_____
Home phone number (with Area Code)

INITIAL EPISODE

8. One cover sheet per Emergency/Initial episode of care.

Date of injury: _____ Duty Dates From:_____ To:_____

Diagnosis: _____

Type of follow-up care recommended: _____

Type of provider: Civilian VA

When treatment received, member was on: IDT ADT AT ADSW UTA (Air Force Only)

NOE/LOD : ADMIN INFORMAL FORMAL

FOLLOW UP CARE

**********completion of initial episode information required for pre-authorizations**********

9. One cover sheet per pre-authorization request.

Pre-Authorization (Treatment plan attached) Yes No

MEB status: N/A In progress-MTF_____ Completed-findings_____

Pre-Authorization Number issued by MMSO for follow-up visit: #

10. Checklist for submitting medical claims:

- **Drill Attendance Sheet or Orders (only initial episode of care).**
- **Approved Line of Duty (All preauthorized follow-up care)**
- **Medical Claim (HCFA 1500, UB 92)**
- **DD Form 2642, (TRICARE Claim Form for Service Member Reimbursement – pharmacy or medical care) if applicable (available at www.tricare.osd.mil)**
- **Possible Third Party Claim (i.e. injury caused by another person, or patient covered by other insurance). Copy of DD 2527 located at http://mmso.med.navy.mil**

Dental Claims are submitted in accordance with the Dental Instruction at http://mmso.med.navy.mil with the drill attendance sheet or NOE/LOD.

11. I certify that this individual is eligible for this care at government expense.

Nearest Military Treatment Facility is located at_____, _____ miles from the reservist/guard's residence.

_____ _____ _____ _____
Signature Printed Name (CO or Medical Representative) Phone Number Date